Can Arbitration Play a Saving Role in Women's Health? The Use of Arbitration in the OB/GYN Specialty

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I. INTRODUCTION

A woman arrives at her obstetrician's office for her annual check-up and to share the good news that she and her husband are trying to have their second child. To her dismay, her physician tells her that he will not be able to be her physician for her pregnancy or for the delivery of her child because he is no longer practicing obstetrics. After being a patient for ten years, and going through the birth of her first child with this physician, Mrs. Smith will have to find a new physician. After years of establishing a rapport and confidence in her physician, Mrs. Smith finds herself in a position of starting over. One may assume that the common reaction is that it is not a big deal and Mrs. Smith will just find another physician. However, it is an issue, and the availability of locating a new obstetrician may not be as easy as one might imagine, especially in a rural area.

This Note addresses the critical state of obstetrics and gynecology (OB/GYN) practices in the United States, the risks it is creating in women's health, and how arbitration could be a key factor in solving this problem. The Note begins by looking at the rising cost of insurance premiums and their effect on the specific practice of OB/GYN and addresses the crisis in the United States that has reached critical levels in nearly half of the states. The current crisis is that OB/GYNs all over the country are dropping obstetric care from their practices due to the dramatic increase in insurance premiums. Part III provides a background of the arbitration process and discusses the feasibility of utilizing contractual binding arbitration clauses between OB physicians and their patients. Part IV proposes a new way to utilize arbitration as an incentive to reduce premiums for OB/GYNs and provide patients a more accessible forum to resolve disputes and receive compensation. This Note concludes by recommending the establishment and practice of arbitration agreements in the specific field of OB/GYN as a way to reduce premiums.

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II. BACKGROUND

A. *Medical Insurance for OB/GYN Physicians*

When a physician practices medicine, there is a possibility that an injury to the patient may occur. The basis of such injury may not always be the physician's fault, but the process that is used to determine that outcome is often expensive and lengthy. As a result, most physicians will take out medical malpractice insurance[1] to assist with potential costs and to protect their livelihood.[2] Insurance coverage is purchased from physician-owned or operated insurance companies,[3] commercial insurance companies, or self-insured physicians.[4]

There are two basic types of malpractice insurance: "claims-made" and "occurrence-made." Claims-made insurance "provides coverage for claims that arise from incidents that occur and are reported during the time the insurance policy is in force."[5] This protects the physician from a malpractice claim only if the company that insured the physician, at the time of the

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[1] The most common policies carried by physicians are $1 million of coverage per incident and $3 million in coverage per year. *See* U.S. GENERAL ACCOUNTING OFFICE, GAO-03-702, MEDICAL MALPRACTICE INSURANCE: MULTIPLE FACTORS HAVE CONTRIBUTED TO INCREASED PREMIUM RATES 6 (2003) [hereinafter GAO-03-702]; *see also* Elizabeth Swire Falker, *The Medical Malpractice Crisis in Obstetrics: A Gestalt Approach to Reform*, 4 CARDOZO WOMEN'S L.J. 1, 12 (1997) (articulating that physicians typically only carry $2–3 million in liability coverage).

[2] Medical malpractice insurance is similar to other types of insurance, in which physicians buy insurance to cover expenses related to medical malpractice claims. *See generally* GAO-03-702, *supra* note 1 (stating that expenses of medical malpractice cases include payments to claimants, either in judgment or settlement, and legal expenses, such as contingent fees for attorneys). The process operates much like other insurance policies. The physicians are the policyholders that pay a premium to the insurers in exchange for the insurers' agreement to defend and pay future claims that fall within the policy. *Id.* at 7.

[3] Physician Insurers Association of America (PIAA) insures approximately 60% of all physicians in private practice in America. *Id.* at 6. The article does not identify common areas of practice. The PIAA is a trade organization of more than fifty professional liability insurance companies owned by physicians. Physician Insurers Association of America, http://www.piaa.us/about_piaa/what_is_piaa.htm (last visited Jan. 4, 2005). Its mission as an organization is to advocate on behalf of physicians, dentists, and other healthcare providers in areas of education, research, risk management and legislation. *Id.*

[4] GAO-03-702, *supra* note 1, at 6. Self-insured physicians take on the responsibility of claims themselves. *Id.*

[5] *Id.* at 55.

alleged injury, is the same company at the time the claim is filed with the court.[6] If the same company is not insuring the physician, the physician is not covered unless the physician purchased "tail" insurance.[7]

The second type of insurance is occurrence-made insurance. This type of coverage provides seamless coverage for the physician even if the physician experiences a job or location change.[8] An occurrence-made insurance policy provides the physician with coverage as long as the physician was insured by that carrier at the time of the alleged occurrence.[9] The physician's insurance provider does not have to be the same insurance carrier when the claim is filed with the court.[10]

B. *An Increase in Insurance Premiums in the OB/GYN Specialty*

Over the past few years, there has been a continual trend in the medical specialty of obstetrics—increased insurance premiums.[11] In the specialty of OB/GYN, there have been reported increases in malpractice insurance premiums ranging from 19.6 percent to 56.2 percent.[12] States without

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[6] Patrick C. Alguire, *Malpractice Insurance*, AM. C. PHYSICIANS, http://www.acponline.org/counseling/malpractice_insurance.htm (last visited Feb. 28, 2006).

[7] Tail insurance is defined as "an option available from a former carrier to continue coverage for those dates that the claims-made coverage was in effect." GAO-03-702, *supra* note 1, at 55. The cost of tail insurance is typically a one time assessment that can be 1.5 to 2 times a standard annual malpractice insurance premium. *See* Alguire, *supra* note 6.

[8] Alguire, *supra* note 6.

[9] *Id.*

[10] Physicians should also be aware of the type of losses that are covered. "Pure loss" is coverage only for the amount awarded to the plaintiff, and "ultimate net loss" is coverage for the attorney's fees and costs as well. *See* Alguire, *supra* note 6. "Claims that arise from incidents occurring during the policy period that are reported after the policy's cancellation date are still covered in the future." *See* GAO-03-702, *supra* note 1, at 55.

[11] *See* Sarah Domin, Comment, *Where Have All the Baby-Doctors Gone? Women's Access to Healthcare in Jeopardy: Obstetrics and the Medical Malpractice Crisis*, 53 CATH. U. L. REV. 499, 541 (2004) (concluding that the trend of increasing medical malpractice claims and high jury awards hit obstetrics the hardest); Robert Ward Shaw, Comment, *Punitive Damages in Medical Malpractice: An Economic Evaluation*, 81 N.C. L. REV. 2371, 2378 (2003) (discussing the trend of increasing healthcare costs, including medical malpractice insurance costs, to which obstetrics and gynecology are particular vulnerable).

[12] William P. Gunnar, *Is There an Acceptable Answer to Rising Medical Malpractice Premiums*, 13 ANNALS HEALTH L. 465, 471 (2004). In Utah, medical

legislated tort reform[13] have experienced dramatic increases in insurance premiums when compared to states that have implemented tort reform legislation.[14] For example, in the context of medical malpractice, California is well-known for its tort reform and is often used as a model by other states.[15] In a comparison between states that have not implemented legislative reform and California, the picture of the OB/GYN crisis starts to become clear. From 1998 to 2002, the largest rate increases in medical malpractice insurance premiums for OB/GYNs have been in Ohio, Oregon, and Pennsylvania, rising 148.5 percent, 126 percent, and 125.3 percent,

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malpractice premiums for OB/GYNs have increased even more dramatically with rates rising by 94% in the last four years. *See Impact of Medical Liability Issues on Patient Care, Cong. Testimony by Federal Document Clearing House*, 108th Cong. (2004) [hereinafter *Hearings*] (statement of Charles W. Sorenson, Jr., MD).

[13] One example of tort reform includes legislation for non-economic damage caps. Recently, Ohio legislated a non-economic cap that limits a non-economic award up to a maximum of $350,000 for each plaintiff or $500,000 if multiple plaintiffs are involved. *See* Bryan A. Liang & LiLan Ren, *Medical Liability Insurance and Damage Caps: Getting Beyond Band Aids to Substantive Systems Treatment to Improve Quality and Safety in Healthcare*, 30 AM. J.L. & MED. 501, 510 n.71 (2004) (illustrating Ohio as one of the states in a crisis mode trying to legislate tort reform, specifically non-economic caps); *see, e.g.*, Kevin J. Gfell, *The Constitutional and Economic Implications of a National Cap on Non-Economic Damages in Medical Malpractice Actions*, 37 IND. L. REV. 773, 801–02 (2004).

[14] States experiencing greater than 50% increases in insurance premiums in 2002 are as follows: Arkansas, 112%; Florida, 75%; Mississippi, 99%; Nevada, 50%; New Hampshire, 50%; Ohio, 60%; Oregon, 80%; Tennessee, 65%; Virginia, 113%. U.S. Dept. of Health & Human Services, *Special Update on Medical Liability Crisis* (September 25, 2002), http://aspe.hhs.gov/daltcp/reports/mlupd1.htm [hereinafter *Special Update*].

[15] California is one of the pioneers in malpractice tort reforms. Its passage of the Medical Injury Compensation Reform Act (MICRA) in 1975 is viewed as some of the most effective legislation in reducing malpractice insurance premiums. *See* Liang & Ren, *supra* note 13, at 505 (discussing the implementation of California's successful legislation and its intended result of providing affordable health care by limiting punitive damages); Lauren Elizabeth Rallo, Comment, *The Medical Malpractice Crisis—Who Will Deliver the Babies of Today, the Leaders of Tomorrow?*, 20 J. CONTEMP. HEALTH L. & POL'Y 509, 512 (2004) (commenting that California's tort reform is viewed as one of the most successful models of reform). Furthermore, the federal government's attempt for tort reform is modeled after California's MICRA. *Id.* at 536; Andrea D. Stailey, Comment, *The Health Act's Same Old Story, Different Congress Dilemma: Overhauling the Health Act and Unifying Congress as a Remedy for Tort Reform*, 40 TULSA L. REV. 187, 198–200 (2004) (stating that the federal act is modeled after California's MICRA and expands on the California legislation to aid in stabilizing liability costs).

respectively.[16] Whereas, the average insurance premium rates in states *with* monetary limits on non-economic damages are lower than the national average as a whole.[17]

C. *Availability of OB/GYN Physicians*

The importance of insurance premiums goes beyond the mere "expense" to the physician. There is a direct correlation between insurance premiums and physician availability.[18] Availability is not limited to geographic accessibility for patients, but also includes availability of physicians in the specialty.

1. *Geographical Availability*

According to the American Medical Association (AMA) 23 states are experiencing a full-blown medical liability crisis.[19] In these crisis states,

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[16] *See Special Update*, *supra* note 14 (referencing the Medical Liability Monitor 2002 Report, Sept. 24, 2002 (preliminary data)).

[17] The total average insurance premium for the United States as a whole is $49,530 for OB/GYNs. *Special Update*, *supra* note 14, at tbl.8. Insurance premiums for OB/GYNs in states with non-economic limits on damages are as follows: Indiana, $19,486; South Dakota, $18,633; North Dakota, $24,971; Hawaii, $42,928; Montana, $40,693; Utah, $45,588; New Mexico, $35,915; California, $48,704. *Id.* The one exception listed is Michigan, which had an average insurance premium of $88,945 for OB/GYNs. *Id.*

[18] A 2002 survey by the American College of Obstetricians and Gynecologists (ACOG) found that 73% of OB/GYN specialists have been forced to retire, relocate, or modify their practice. Alex Adrianson, *Why Doctors Are Quitting Medical Practice*, CONSUMER'S RES. MAG., June 2003, at 10 (discussing OB/GYNs altering or leaving their practice in states such as Missouri, Nevada, Kentucky, Washington, West Virginia, Pennsylvania, and New York because of malpractice premiums). A correlation is drawn when these states are cross-referenced with the ACOG's Red Alert states. *See* The American College of Obstetrician and Gynecologists, ACOG's Red Alert on Ob-Gyn Care Reaches 23 States (Aug. 26, 2004), http://www.acog.org/from_home/publications/press_releases/nr08-26-04.cfm [hereinafter Red Alert on Ob-Gyn Care]; *see, e.g.*, Betsy Bates, *Liability Crisis Drives Away OBs; ACOG Issues Red Alert*, OB GYN NEWS, June 15, 2002.

[19] Red Alert on Ob-Gyn Care, *supra* note 18. For example, in Massachusetts, a confluence of factors led the AMA to add Massachusetts to the list. Among them: 50% of neurosurgeons, 41% of orthopedic surgeons, 36% of obstetricians, and 29% of general surgeons have reduced their scope of practice. The number of jury awards of more than $2 million quadrupled over five years. Median settlements in medical negligence cases increased to $925,000 in 2002, up from $600,000 in 2000. Amednews.com,

physicians are "retiring early, discontinuing high-risk services[,] or leaving the state altogether because of high medical liability insurance rates."[20] The rising insurance premiums result in states experiencing critical physician shortage,[21] particularly in obstetrical care.[22] For example, in a Mississippi town, where the population is less than 20,000, women no longer have obstetric care.[23] In Utah, women have fewer and fewer options regarding obstetric care, making the specialty of obstetrics a critical area of concern.[24] As of October 2002 in Clark County, Nevada, there were only 106 physicians performing deliveries for an estimated 23,000 expected deliveries.[25]

The American College of Obstetricians and Gynecologists[26] (ACOG) continues to identify states that are in a crisis mode for women's health. In 2002, ACOG identified 16 states that were categorized at "Red Alert" status.[27] By 2004, the ACOG identified seven more, bringing the total to 23

Massachusetts Earns Dubious Distinction, (July 5, 2004), http://www.ama-assn.org/amednews/2004/07/05/prl10705.htm.

[20] Amednews.com, *supra* note 19.

[21] According to the AMA, the states experiencing a full-blown medical liability crisis include Arkansas, Connecticut, Florida, Georgia, Illinois, Kentucky, Massachusetts, Mississippi, Missouri, Nevada, New Jersey, New York, North Carolina, Ohio, Oregon, Pennsylvania, Texas, Washington, West Virginia and Wyoming. *Id.*

[22] Gunnar, *supra* note 12, at 471 (stating there is also a reported shortage in neurosurgical care).

[23] *Id.* at 473.

[24] *Hearings*, *supra* note 12 (referring to a statement made by Charles W. Sorenson, Jr.).

[25] The American College of Obstetricians and Gynecologists, The Facts of the Liability Crisis, http://www.acog.org/departments/dept_notice.cfm?recno=11&bulletin=2688 (last visited Feb. 28, 2006) [hereinafter The Facts of the Liability Crisis].

[26] The ACOG is a national medical organization representing over 46,000 members who provide health care for women. *See* The American College of Obstetricians and Gynecologists, *The American College of Obstetricians and Gynecologists Celebrating 50 Years of Improving Women's Health,* http://www.acog.org/from_home/acoginfo.cfm (last visited Feb. 28, 2006).

[27] Red Alert status is determined by a number of factors established by the ACOG. In addition to the state's tort reform history, such factors include:

> the lack of available professional liability coverage for ob-gyns in the state; the number of carriers currently writing policies in the state, as well as the number leaving the medical liability insurance market; the cost, and rate of increase, of annual premiums based on reports from industry monitors; a combination of geographical, economic, and other conditions exacerbating an already existing shortage of ob-gyns and other physicians . . . .

states. Nearly half of the nation's states are faced with disruptions to obstetrical care.[28] As a result of rising premiums, OB/GYNs are faced with decisions such as dropping obstetrics from their practice, retiring, relocating, decreasing gynecological surgical procedures, decreasing the number of deliveries, and decreasing the amount of high risk obstetric care.[29]

2. *Physicians Elect Not to Specialize in OB/GYN*

The availability of OB/GYN physicians is also affected by medical students' specialty election. In 2004, the number of U.S. medical students entering the specialty of OB/GYN declined for the third consecutive year; only 65% of the residency openings for OB/GYN were filled by U.S. medical students.[30] Also, the sweeping trend of women patients selecting female physicians has severely affected the number of male students electing OB/GYN as a specialty.[31] The continuation of these trends will result in women's inability to receive accessible care because new doctors are turning away from the specialty.[32]

The availability of OB/GYN physicians is not only a future concern. It is a current issue. One out of seven OB/GYN physicians has left the practice of medicine.[33] The driving force behind this movement is the fear of being sued

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The American College of Obstetricians and Gynecologists, Red Alert: The Hot States (May 6, 2002), http://www.acog.org/from_home/publications/press_releases/nr05-06-02-2.cfm.

[28] Red Alert on Ob-Gyn Care, *supra* note 18; *see also* The Facts of the Liability Crisis, *supra* note 25.

[29] Mary Ellen Schneider, *Maryland: A State in 'Crisis' for Ob.gyns*, OB GYN NEWS, Oct. 15, 2004, *available at* 2004 WLNR 12140522 (discussing each of the listed actions taken by OB/GYNS); *see also* GOP Fast Facts, Medical Liability, http://www.rpof.org/fastfacts/medical/ (last visited Feb. 28, 2006).

[30] Schneider, *supra* note 29.

[31] John T. Queenan, MD, *The Future of Obstetrics and Gynecology*, 102 OBSTETRICS & GYNECOLOGY 441, 441–42 (2003) (stating that as men shy away from obstetrics due to less market demand for male OB/GYN physicians the pool of applicants for OB/GYN residency programs has been nearly cut in half).

[32] The American College of Obstetricians and Gynecologists, Medical Liability Survey Reaffirms More Ob-Gyns Are Quitting Obstetrics (July 16, 2004), http://www.acog.org/from_home/publications/press_releases/nr07-16-04.cfm [hereinafter Medical Liability Survey].

[33] The percentage presented is representative of the OB/GYN physicians through a survey of ACOG's fellows. "[O]ne in seven ACOG Fellows report[s] that they had stopped practicing obstetrics because of the high risk of liability claims." *Id.*

and the high risk of liability claims.[34] OB/GYNs have an average of 2.6 claims filed against them during the life of their careers.[35] The existence of claims, however, does not equate to negligence by the physician.[36]

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[34] *Id.*

> In a recent ACOG survey, 76.3% of the Florida ob-gyns who responded indicated that they have changed their practices as a result of this crisis. These changes included retiring, relocating, decreasing gynecologic surgical procedures, no longer performing major gynecologic surgery, and decreasing the number of deliveries and amount of high-risk obstetric care. 21.69% of Florida respondents indicated that they stopped practicing obstetrics due to the unavailability and unaffordability of liability insurance. . . . .According to the *Delta Democrat Times*, 324 Mississippi physicians stopped delivering babies in the last decade. Only 10% of family physicians deliver babies. In the ACOG practice change survey, 86.2% of responding Nevada ob-gyns indicated that they have changed their practices, with 27.59% dropping obstetrics.

The Facts of the Liability Crisis, *supra* note 25. Additional changes, due to liability costs and availability, within the OB/GYN practice include: a decrease in the amount of high-risk obstetric care, 25.2%; a decrease in the number of deliveries, 12.2%; physicians no longer practicing obstetrics, 9.2%; a decrease in gynecologic surgical procedures performed, 14.8%; physicians no longer doing major gynecologic surgery, 5.4%. Medical Liability Survey, *supra* note 32; *see also* Interview by CNBC Kudlow & Cramer with Bill Brock (Sept. 15, 2004). The statistics listed above are extremely similar to the changes reported by the ACOG, after surveying their fellows, in response to the risk of liability claims or being sued. The ACOG reported: a decrease in the amount of high-risk obstetric care, 22%; obstetricians that stopped offering/performing VBACs, 14.8%; a decrease in the number of deliveries, 9.2%; physicians no longer practicing obstetrics, 14%; a decrease in gynecologic surgical procedures performed, 12.3%; and physicians no longer doing major gynecologic surgery, 5.6%. *Medical Liability Survey*, *supra* note 32.

[35] Red Alert on Ob-Gyn Care, *supra* note 18. A detailed breakdown of the various claims sought against OB/GYNs are as follows:

> Obstetric claims accounted for 61% of claims against ob-gyns; 38% were gynecologic claims. From 1999–2002, the top four primary obstetric allegations were: neurologically impaired infant (34%); stillbirth/neonatal death (15%); other infant injury—major (7%); and delay in or failure to diagnose (7%). From 1999–2002, the top four primary gynecologic allegations were: delay in or failure to diagnose (29%); patient injury—major (25%); patient injury—minor (15%); and other/non-*specified (12%).*

Medical Liability Survey, supra note 32.

[36] A physician may have a claim brought against them but slightly less than half of the time the claim is dropped.

> Almost half (49.5%) of claims against ob-gyns are dropped by plaintiffs' attorneys, dismissed or settled without payment. Of cases that do proceed to court, ob-gyns win eight out of ten times (81.3%) . . . . Closed claim resolution experience: No payout—49.5%; Dropped by plaintiff—33.6%; Dismissed by court—13%; Settled

OB/GYNs rank *number one* among 28 specialty groups in the number of claims filed against them.[37] Additionally, the average cost of defending a medical malpractice suit for an OB/GYN is the highest among all specialties.[38] In the 1990s, OB/GYNs were second to neurologists in the average claim payout, but moved into first place by 2000 with the average claim payment being just under $400,000.[39] Based on these facts, one might conclude that there is a direct correlation between increased claims and negligence; however, that is not true. Over half of the claims brought against OB/GYNs are dropped by plaintiff attorneys, dismissed, or settled without payment.[40] In cases that proceed to trial, OB/GYNs were awarded favorable decisions in more than 65% percent of the resolved cases.[41] From an alternative perspective, a plaintiff received a favorable decision only nine percent of the time when the case reached a jury or court verdict.[42] Accordingly, to attain a resolution of a claim through the judicial process requires vast sums of time and money, and takes an emotional toll on the physician.[43]

In cases that reach a jury verdict, the awarded payouts can be staggering.[44] In obstetrics, a physician is caring for the health of both the

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without payment—2.9%; Settled with payment—36.0%; Arbitration or other alternative dispute resolution mechanism—2.7%; Jury/court verdict—8.6%.

Medical Liability Survey, *supra* note 32.

[37] *Medical Liability Insurance—American College of Obstetricians and Gynecologist: Before the House Government Reform Committee Subcommittee on Human Rights and Wellness*, 108th Cong. (2003) [hereinafter *Hearing*] (statement of ACOG).

[38] The average cost listed in 2000 was $34,308. *Id.*

[39] *Id.*

[40] The reported figure of dismissed claims without settlement is 53.9%. *Id.*

[41] *Id.*

[42] Medical Liability Survey, *supra* note 32.

[43] In 2000, the average cost of litigation for a claim was $34,308. *See supra* note 38 and accompanying text. Emotionally, a physician can feel angry and confused. Many times the emotions experienced by the physician are not able to be put into words because a physician does not need to be found liable of malpractice to suffer the affects of a lawsuit. *See* John Gibeaut, *The Med-Mal Divide*, A.B.A. J., Mar. 2005, at 44.

[44] "The average jury award in cases of "neurologically impaired infants," which account for 30% of the types of claims against obstetricians, is nearly $1 million, but the figure can soar much higher. One recent award in a Philadelphia case reached $100 million." The American College of Obstetricians and Gynecologists, Nation's Obstetrical Care Endangered by Growing Liability Insurance Crisis (May 6, 2002), http://www.acog.org/from_home/publications/press_releases/nr05-06-02-1.cfm.

mother and unborn child.[45] In that regard, OB/GYNs are particularly vulnerable to increased medical liability awards because every time a newborn child is not "perfect," there is a chance of a lawsuit.[46] The amount of medical liability awards has increased dramatically over the past few years, rising to median levels of over $2,000,000.[47] For example, the median medical liability award jumped from $700,000 in 1999 to $1,000,000 in 2000.[48] In October 2003, the median award for childbirth cases was $2,050,000—it is the highest of all medical liability cases.[49]

In addition to large monetary awards, the average length of time from filing a complaint to the closing of an OB/GYN medical malpractice claim is four to seven years.[50] Based on these factors, it is necessary to find or create a more efficient, streamlined process to quickly weed out non-meritorious claims and provide compensation for those who have truly been injured. As this Note proposes, the implementation of an arbitration model could be the necessary catalyst to aid in reshaping the approach of medical malpractice insurance premiums for OB/GYNs.

III. MAKING THE MOVE TO ARBITRATION

The perception of OB/GYN physicians is that they are constantly targeted for lawsuits anytime a baby is not perfect.[51] It is this fear that is a

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[45] Obstetrics is defined as "[t]he specialty of medicine concerned with the care of women during pregnancy, parturition, and the puerperium." STEDMAN'S CONCISE MEDICAL DICTIONARY FOR THE HEALTH PROFESSIONS 616 (3d ed. 1997).

[46] *See* Nancy Pariser, Letter to the Editor, *Springtime for Obstetrics and Gynecology: Will the Specialty Continue to Blossom?*, 103 OBSTETRICS & GYNECOLOGY 197 (2004), *available at* http://www.greenjournal.org/cgi/content/full/103/1/197 (providing her opinion as a physician that "[physicians] are held to the impossible standard of delivering the perfect baby. Anything short of the perfect baby with our current system is guaranteed malpractice litigation").

[47] *Hearing, supra* note 37, at II, ¶6 (statement of ACOG).

[48] *Id.*

[49] *Id.*

[50] Thirteen percent of OB/GYN cases take more than seven years. Medical Liability Survey, *supra* note 32; *see also* U.S. DEP'T OF HEALTH & HUM. SERVS., NATIONAL PRACTITIONER DATA BANK: 2003 ANN. REP. 4 (2003) *available at* http://www.npdb-hipdb.com/pubs/stats/2003_NPDB_Annual_Report.pdf (reporting that for physician medical malpractice payments the mean time period between an incident that lead to a payment and the payment itself was 4.59 years).

[51] James Pinkerton, *Liability War Zones; Doctors Assail Lawsuit Abuses, Insurance Costs,* HOUS. CHRON. RIO GRANDE VALLEY BUREAU, June 19, 1994; *see also* Pariser, *supra* note 46.

driving force behind their decisions to stop practicing obstetrics and delivering babies.[52] The use of arbitration[53] may aid in subduing these fears because it can provide a contractually binding agreement to settle disputes between the parties while eliminating the potential, lengthy process of the judicial system.[54] Without a new approach, the risk of physicians dropping obstetrics from their practice will not only continue but increase.

A. *Creating a Standard Practice of Arbitration for OB/GYNs*

The purpose of arbitration is to provide an out-of-court method that parties can utilize to reduce the cost of litigation by agreeing to resolve their dispute using a mutually agreed upon arbitrator.[55] The Federal Arbitration Act (FAA) passed in 1925 enabled the courts to uphold arbitration clauses and put such clauses on equal footing with other contractual agreements.[56]

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[52] *See supra* note 34 and accompanying text.

[53] This Note will focus on the use of arbitration and not mediation. The use of mediation does not provide a binding decision upon which insurance companies can use in actuary models.

> Mediation has been defined by the American Arbitration Association as "intervention by an impartial third person with the purpose of helping the parties reach their own solution." Thus, mediation differs from arbitration in that the latter usually involves a final and binding decision by [a] neutral third party, whereas a mediation process usually requires the third party to act only as a facilitator, and to allow the parties themselves to reach an agreement. A mediation agreement is enforceable under state contract law, whereas an arbitration award can be enforced either under federal labor laws . . . or under state or federal arbitration acts which provide for labor and commercial arbitration enforcement.

Jan William Sturner, *Arbitration, Labor Contracts, and the ADA: The Benefits of Pre-Dispute Arbitration Agreements and an Update on the Conflict Between the Duty to Accommodate Seniority Rights*, 21 U. ARK. LITTLE ROCK L. REV. 455, 471 n.71 (1999) (citations omitted).

[54] *See* Thomas E. Carbonneau, *Arbitral Justice: The Demise of Due Process in American Law*, 70 TUL. L. REV. 1945, 1945 (1996) (defining arbitration as a process that parties can use to resolve disputes in a final and binding manner outside the tradition court system).

[55] Shelly Smith, *Mandatory Arbitration Clauses in Consumer Contracts: Consumer Protection and the Circumvention of the Judicial System*, 50 DEPAUL L. REV. 1191, 1192 (2001). "[A]rbitration is a process whereby parties voluntarily submit their disputes for resolution by one or more impartial third persons, instead of by a judicial tribunal provided by law." *Id.* at 1192 n.7 (citing Thomas J. Stipanowich, *Rethinking American Arbitration*, 63 IND. L. J. 425, 425 n.1 (1988)).

[56] *Id.* at 1197.

The rationale of the FAA was to create a process that aided in reducing the cost of dispute resolution and encouraged adverse parties to salvage their relationship.[57] This rationale is identical to the underlying requirements for establishing a dispute resolution practice standard in OB/GYN medical malpractice claims.[58]

An additional requirement for a successful arbitration model in the OB/GYN specialty is confidentiality.[59] As discussed, OB/GYNs have the highest rates of claims, not as a result of proven negligence, but as a result of circumstance.[60] The filing of one claim can have the effect of branding a physician as "negligent," thus impairing the physician's ability to attract new patients.[61] Oftentimes, a claim against the physician is publicized, but the dismissal is not.[62]

The requirement of confidentiality is not inherent in arbitration agreements, nor is the requirement of a written opinion.[63] When a dispute is arbitrated privately, the decision does not act as precedent for future decisions.[64] This can be attractive for physicians because previous claims or

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[57] *Id.* at 1220 ("promot[ing] extra-judicial resolution of disputes for various public policy reasons, including the reduction in the cost of dispute resolution and the encouragement of adverse parties to salvage their relationships").

[58] *Id.*

[59] The insurance of confidentiality is important to physicians. *See* Elizabeth Rolph et al., *Arbitration Agreements in Health Care: Myths and Reality*, LAW & CONTEMP. PROBS., Winter & Spring 1997, at 153, 155 ("Providers, particularly physicians, welcome the confidentiality of the private arbitration forum. Allegations of negligence are often highly personalized attacks, which many providers prefer to keep from public view.").

[60] OB/GYNs have the highest number of claims bought against them, yet over 50% are dismissed or settled without payment. *See supra* note 36 and accompanying text.

[61] Many times physicians learn of lawsuits through newspaper articles and word of mouth. For example, Dr. Kopen had removed a patient's gallbladder and four years later was sued by the patient for failure to discover the patient's colon cancer. The suit was dropped but Dr. Kopen stated that the publicity caused referrals to "nosedive" for his intestinal and colonic procedures. Dr. Kopen stated that his practice has never fully recovered. *See* Gibeaut, *supra* note 43, at 39.

[62] *Id.*

[63] Smith, *supra* note 55, at 1222 ("[M]any arbitration forums and contracts do not require written opinions and even go as far as requiring confidentiality of the arbitration altogether.").

[64] Unless disputants require otherwise, arbitrators need not provide a written statement of their reasoning. Even if such a statement is required, it has no precedential value. Thus, disputes proceeding to resolution in arbitration are not integrated into the dynamic process of creating case law. Precisely because health

settlements will not establish precedent.[65] This is important because the circumstances of each patient's care are unique and claims are subject to distinct fact patterns. Each case must be evaluated on its own merits and the settlement from a previous case cannot act as a pre-determinate for a subsequent case.[66] To that end, arbitration can provide a forum to discuss the particular merits of the present dispute (between the patient and the physician) without the risk of casting a negative persona of the physician before causation is determined.

It is important to note, however, that an arbitration clause in a contractual agreement is not an absolute determinate that parties can only resolve their dispute through arbitration. Although the United States Supreme Court has a history of enforcing arbitration agreements under the FAA,[67] a window still exists for litigation, even when an arbitration clause is present in the contract.[68] Therefore, a patient is not completely foreclosed from litigation by agreeing to arbitration.[69]

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care delivery is undergoing such profound and rapid change, large numbers of health care disputes should not be removed from the courts.

Rolph, *supra* note 59, at 156. *See also* Smith, *supra* note 55, at 1222–23.

[65] Smith, *supra* note 55, at 1223, (discussing the relationship between arbitration and precedent). Concurrently, the patient may not view this as "advantageous" to their position because they may not have knowledge of previous cases. *Cf. Id.* at 1244 (comparing a consumer to a patient).

[66] Rolph et al., *supra* note 59, at 156; *see also* Smith, *supra* note 55, at 1231 n.295 ("Advocates for arbitration view the lack of a written opinion as a benefit that makes arbitration a more efficient process than litigation . . . . They serve to put an effective end to dispute resolution, preventing a case from dragging on for months or years in the appeal stage.") (citations omitted).

[67] *See generally* Green Tree Fin. Corp. v. Randolph, 531 U.S. 79 (2000) (holding that the risk of being saddled with prohibitive costs was too speculative to justify invalidating the arbitration agreement); Doctor's Assocs. v. Casarotto, 517 U.S. 681 (1996) (holding that the Montana state statute is preempted by the Federal Arbitration Act); Rodriguez De Quijas v. Shearson/Am. Express, Inc., 490 U.S. 477 (1989) (holding that the arbitration clause was valid because it was a procedural remedy and did not affect the substantive provision of the Securities Act of 1993); Perry v. Thomas, 482 U.S. 483 (1987) (holding that the Federal Arbitration Act preempted a California statute authorizing appellee to maintain an action despite the existence of an arbitration agreement); Mitsubishi Motors Corp. v. Soler Chrysler-Plymouth, Inc., 473 U.S. 614 (1985) (holding that the arbitration agreement or the forum selection was not invalidated based on the antitrust claim alone).

[68] Smith, *supra* note 55, at 1241.

[69] A patient's right to seek judicial remedies through litigation may not be foreclosed if the suit is based on a statutory violation that provides a preclusion of judicial remedies. A statute enacted by Congress may preclude a waiver of judicial

The use of arbitration in OB/GYN medical malpractice cases will streamline the process and act as a better predictor for insurance companies, which in turn could be utilized to reduce insurance premiums.[70] Furthermore, arbitration will ease court congestion, is less expensive, and affords expeditious disposition of disputes.[71] Litigation in OB/GYN cases, on the other hand, exacts longer timeframes and more expenses than most other medical specialties.[72] The right to voluntarily enter into binding arbitration of medical malpractice claims is recognized and available as long as the contract to arbitrate is drafted in a prescribed form according to the state's statutes.[73] Physicians are seeking out alternative solutions to help combat the high risk of liability—solutions like arbitration. States need to provide the capabilities and support for such a solution.[74]

B. *Finding the Right Type of Arbitration*

Mandatory binding arbitration is typically found in consumer product agreements and employment law.[75] Simply copying the models of mandatory

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remedies, such as arbitration, in which it would provide an exception to compel arbitration of statutory rights under the FAA. *See* Smith, *supra* note 55, at 1241 (citing Gilmer v. Interstate/Johnson Lane Corp., 500 U.S. 20, 26 (1991); Randolph v. Green Tree Fin. Corp., 991 F. Supp. 1410, 1420 (M.D. Ala. 1997)).

[70] *See* discussion *infra* Part IV.A.

[71] Hilleary v. Garvin, 238 Cal. Rptr. 247, 249 (Cal. Ct. App. 1987) (citing Hawkins v. Superior Court, 152 Cal. Rptr. 491, 493 (Cal. Ct. App. 1979)) (finding that the parties have the right to voluntary arbitration of medical malpractice claims because it is a method that is less expensive, eases court congestion, and affords an expeditious disposition of the matter).

[72] *See supra* notes 34–35 and accompanying text.

[73] California's codification of the right to arbitrate medical malpractice can be found in the Code of Civil Procedure § 1295(a) providing: "[a]ny contract for medical services which contains a provision for arbitration of any dispute as to professional negligence of a health care provider shall have such provision as the first article of the contract . . . ." CAL. CIV. PROC. CODE § 1295(a) (West 1982).

[74] Brian Rust, *Physicians Seek Arbitration to Protect Them from Lawsuits*, DAILY UNIVERSE, Oct. 14, 2004; *see also* Jennifer Silverman, *Patients Asked to Sign Contracts: Company Offers Plans to Curb Frivolous Lawsuits*, OB GYN NEWS, May 1, 2004 (stating that physicians are taking a stance against malpractice lawsuits by asking their patients to sign an agreement, specifying that they won't sue for any frivolous reason).

[75] *See generally* Michael R. Holden, *Arbitration of State-Law Claims by Employees: An Argument for Containing Federal Arbitration Law*, 80 CORNELL L. REV. 1695, 1699–1703 (1995) (discussing the shift toward arbitration in employment law and its use as the primary means of resolving labor disputes); Smith, *supra* note 55, at 1191–93 (opining

binding arbitration from these areas of law and applying it to OB/GYN-patient agreements would not produce the desired result.[76] The underlying dynamics of mandatory binding arbitration, however, can be utilized to help construct a standardized practice of arbitration in the field of OB/GYN medical malpractice cases.[77]

A mandatory binding arbitration clause is a clause found in a contract that stipulates both parties have agreed that if a dispute arises the parties will arbitrate out of court, waiving their rights to the judicial system.[78] In consumer law, the standard is that a mandatory arbitration clause is on a "take it or leave it" basis.[79] Most companies require the consumer to sign the agreement before they will do business with them.[80] The arbitration clauses in these agreements are seldom discussed with the consumer and the consumer does not seek legal advice before entering into the agreement.[81] This approach is unacceptable in the medical malpractice context, and does not meet the established standard for an arbitration agreement between an OB/GYN and his or her patient.[82] However, this does not deter the use of mandatory arbitration for medical malpractice claims.

Another contention against mandatory binding arbitration is its constitutionality within the context of medical malpractice claims.[83] "The

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that under modern consumer law, consumers are forced into arbitration and banned from the judicial system).

[76] *See generally* Holden, *supra* note 75; Smith, *supra* note 55.

[77] The underlying mechanics referenced are the basic elements of both parties entering into a contractual agreement, stipulating the mandatory requirement to arbitrate and the binding affect of the resolution handed down by the arbitrator. *See* 9 U.S.C. § 2 (2000).

[78] Smith, *supra* note 55, at 1194.

[79] *Id.* at 1192.

[80] *Id.*

[81] *Id.*

[82] Various state supreme courts have held that arbitration agreements are not enforceable if they are entered into under a pressured situation or without the understanding of the patient. *See* Broemmer v. Abortion Services of Phoenix, Ltd., 840 P.2d 1013, 1017–1018 (Ariz. 1992) (holding that the agreement to arbitrate was an adhesion contract because it was beyond reasonable expectations); Wixted v. Pepper, 693 P.2d 1259, 1260–61 (Nev. 1985) (holding that a mandatory arbitration agreement was unenforceable when it was included in a form given to a patient at a clinic to sign before receiving treatment); Sosa v. Paulos, 924 P.2d 357, 363–64 (Utah 1996) (holding the mandatory arbitration clause was procedurally unconscionable where a patient was given the agreement to arbitrate all medical malpractice claims "minutes away" from surgery).

[83] It has been argued that mandatory binding arbitration clauses are unconstitutional on the basis that they violates the 7th Amendment, an individual's right to a jury trial.

Supreme Court has interpreted the purpose of the FAA as not to compel arbitration in every circumstance, but to compel arbitration in a manner provided for by contract when the parties mutually agree to arbitrate."[84] The Supreme Court has held that "[a]rbitration is simply a matter of contract between parties; it is a way to resolve those disputes—but only those disputes—that the parties have agreed to submit to arbitration."[85] This interpretation of the FAA requires that the parties intend to enter into an arbitration agreement, not just sign an agreement. The parties' intention is determined by the court before a mandatory arbitration clause can be enforced.[86]

1. *Consumer Law: Taking the Good, Leaving the Bad*

The use of arbitration in consumer contracts has been successful; thus, it is prudent to try and utilize its strengths in the implementation and enforcement of arbitration in OB/GYN medical malpractice claims. There are, however, strong differences between the two markets that prohibit utilizing an identical pattern. For example, in consumer law transactions, such as credit card contracts, consumers receive agreements in the mail which do not adequately explain the terms of the agreement in a way that a lay person would understand.[87] Additionally, consumers do not even

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Marissa Dawn Lawson, *Judicial Economy at What Cost? An Argument for Finding Binding Arbitration Clauses Prima Facie Unconscionable*, 23 REV. LITIG. 463, 469–70 (2004) (discussing the Supreme Court's analysis of procedural rights versus substantive rights and the ability to waive the right to a jury trial by an arbitration agreement if it is a procedural right). However, the United States Supreme Court has held that, in certain circumstances, mandatory binding arbitration is not a violation of an individual's constitutional right to trial by jury. *Id; see also* Mitsubishi Motors Corp. v. Soler Chrysler-Plymouth, Inc., 473 U.S. 614, 628 (1985).

[84] Smith, *supra* note 55, at 1236 (discussing the possibility that mandatory arbitration clauses may violate contract law and the importance of knowing the parties' intentions).

[85] *Id.*

[86] *Id.* at 1236–37. Problems may arise when parties do not have equal bargaining powers or unknowingly consent to waive their right to access the judicial system under the 7th and 14th Amendments. *Id.* at 1220.

[87] Credit card contracts are typically difficult to understand. *See* Libby Wells, Understanding Credit Card Contracts http://www.bankrate.com/brm/news/cc/19991101a.asp (last visited Feb. 28, 2006) ("It's a guarantee [a consumer] will have difficulty interpreting the fine print. As [one] read[s] the contract, underline parts that are incomprehensible, take notes and then ask the card company for clarification.").

typically read the terms of the agreement.[88] This differs dramatically from the physician-patient relationship and the coinciding arbitration agreements. In cases when there was not a reasonable expectation for the patient to understand the clause, or the timing was inappropriate, courts have refused to uphold contractual agreements containing arbitration clauses between patients and physicians.[89] The result of these cases reinforces the concept that as part of a standardized arbitration model, the physician must discuss the arbitration agreement with the patient and the patient must enter it voluntarily.

i. *Party Differences: Consumer v. Patient and Corporate v. Physician*

The analogous relationship between both sets of parties demonstrates the difference between consumers and patients. In consumer law, many consumers are denied the use of the judicial system because they unknowingly agreed to some alternative dispute resolution method found in the agreement.[90] In OB/GYN cases, however, tolerance for such practices would not exist. This is because of the unique nature and factors of OB/GYN practice.[91]

The patient-physician relationship is a continual relationship that is built on trust and performance; the relationship between a woman and her OB/GYN is unique.[92] A woman will usually select a physician with whom

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[88] *See* Russell Korobkin, *Bounded Rationality, Standard Form Contracts, and Unconscionability*, 70 U. CHI. L. REV. 1203, 1217 (2003) (elucidating that commentators have routinely observed that consumers often fail to read the standard terms in contracts); *see also* R. Ted Cruz & Jeffrey J. Hinck, *Not My Brother's Keeper: The Inability of an Informed Minority to Correct for Imperfect Information*, 47 HASTINGS L.J. 635, 635–36 (1996) (stating that the "typically fine-print terms are frequently not read by those that sign the contracts").

[89] *See* cases cited *supra* note 82.

[90] Smith, *supra* note 55, at 1192.

[91] The care an OB/GYN provides to her patients is an ongoing service that cannot be viewed as a single transaction. For a woman, her OB/GYN is essentially her primary care physician because she establishes a rapport with the physician, who will typically examine the woman once a year, regardless of illness. Furthermore, she is entrusting the care of her health and potentially the health of an unborn child to the physician.

[92] Palo Alto Med. Found., 1997 Annual Report: Mary Ann Sarda-Marudo, MD, http://www.pamf.org/about/annual/profiles/ar97_sardamaduro.html (last visited Feb. 28, 2006) ("[T]he relationship between a mother and her obstetrician is unlike any other doctor-patient relationship—and that uniqueness becomes clear whenever she meets one

she feels comfortable and can build a long-term relationship. Additionally, the OB/GYN has the responsibility of not only understanding the woman's health issues, but also all of her fertility and prenatal issues—the mother and unborn child are two patients in one.

The differences between the physician and the "corporate entity" may not seem as apparent as the consumer versus the patient but they are just as distinguishable. In the consumer environment, there is usually a party which is financially powerful.[93] The other party is typically an individual who does not have financial or legal resources, is inexperienced, and is possibly uneducated.[94] In medical malpractice cases, the physician is often viewed as a financial "deep pocket," which is not always true.[95] Physicians are not typically independently wealthy or have endless amounts of money.[96] Annual insurance premiums can be as much as 30 percent of an OB/GYN's expected income.[97] This expense is paid by the physician each year and is not refunded at the conclusion of the year if zero claims have been filed.

Moreover, in consumer law, the parties do not create relationships that are formed on the most intimate level.[98] The standard transaction in the

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of her patients. There's a special bond that develops that transcends the usual doctor-patient relationship to a much more personal level.") (internal quotations omitted).

[93] The party is typically a corporation or large organization. Smith, *supra* note 55, at 1226.

[94] *Id.* at 1227.

[95] *See* The Asset Protection Law Center, The New "Deep Pockets", http://www.rjmintz.com/new-deep-pockets.html (last visited Feb. 28, 2006) (illustrating how a physician may be stereotyped as being a deep pocket). The belief that the insurance provider is the deep pocket being sued is not correct because over 60% of the cost of malpractice insurance is paid for by physicians. *See* Gunnar, *supra* note 12, at 478 (explaining the burden of the overall cost of malpractice insurance is shouldered by the physicians).

[96] *See* Neil Vidmar, *Empirical Evidence on the Deep Pockets Hypothesis: Jury Awards for Pain and Suffering in Medical Malpractice Cases*, 43 DUKE L.J. 217, 225 (1993) (offering explanations as to why jury awards are 2.5 times higher against doctors than individuals and 85% larger than against hospitals). One explanation presented by the author is that "jurors may act on their beliefs that doctors and hospitals are heavily insured or wealthy." *Id.*

[97] For example in Ohio, OB/GYNs pay an average of 30% of their annual income to malpractice insurance. This is 50% more than the average physician pays to medical malpractice. Ohio Dep't of Ins., Physician Medical Malpractice Insurance Survey (Feb. 2005), http://www.ohioinsurance.gov/documents/exec_summary.pdf.

[98] Consumer law is "[t]he area of law dealing with consumer transactions—that is, a person's obtaining credit, goods, real property, or services for personal, family, or household purposes." BLACK'S LAW DICTIONARY 335 (8th ed. 2004).

consumer market is an exchange of goods that is accompanied by an agreement that sets forth governing terms in case one of the parties is not satisfied. It is a transaction that is conducted at arms length and can hardly be called a "relationship." For example, the credit card industry includes arbitration agreements in adhesion contracts on a "take it or leave it" basis because it knows that if a consumer refuses the contract, there is a large pool of other consumers that can be targeted. Furthermore, a consumer can just wait for the next credit card offer with better terms and conditions.

The option of simply selecting another OB/GYN physician or even having a choice of physicians may not exist if the current trends continue for OB/GYN services.[99] Thus, the option of simply leaving in response to a mandatory arbitration clause[100] will not work if another OB/GYN providing obstetric services is not available. The validity of a mandatory arbitration agreement is based on the arbitration agreement not being a prerequisite to treatment.[101] The "mandatory" part of arbitration can only be enforced once the physician and the patient *voluntarily* form a contractual agreement.

The differences between consumer transactions and the necessities for medical malpractice arbitration agreements in the OB/GYN context extend beyond the contract formation stage. In the OB/GYN environment, the relationship between the parties is more than a contractual agreement, it is a highly personal relationship that continues year after year and can encompass children: born, unborn, or not yet conceived.

2. *Effect of Arbitration on a Minor or Child*

There is an additional layer of complexity that must be raised when discussing the use of an arbitration model in the OB/GYN specialty. In the context of OB/GYN, the parties agreeing to arbitration may not be limited to just the physician and patient, but may also include the "in utero fetus" or delivered child.[102] This is because the mother (or parent) may have the

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[99] Women in some geographical areas are already faced with having one option or none in selecting an OB/GYN. *See supra* notes 20–25 and accompanying text.

[100] *Cf.* Margaret M. Harding, *The Limits of the Due Process Protocols*, 19 OHIO ST. J. ON DISP. RESOL. 369, 391–92 (2004) (discussing the use of pre-dispute arbitration clauses in employment; requiring the employee to agree on arbitration for disputes with the employer as a condition of employment prior to knowing the exact nature of the claim).

[101] Carol A. Crocca, J.D., Annotation, *Arbitration of Medical Malpractice Claims*, 24 A.L.R. 5th 54–56 (1994).

[102] An "in utero fetus" is "an unborn young . . . from the end of the eighth week [after conception] to the movement of birth" that is "[w]ith-in the womb; not yet born."

ability to bind the child to arbitration until the child's maturity at age eighteen.[103] As a result, a mother can deny her child a judicial forum for claims arising from prenatal or delivery care.[104]

A parent's power to bind a child to arbitration did not always exist. Under common law, parents had no authority to waive a claim by a child;[105] however, the common law can be abrogated by a state's statutes.[106] Multiple states have promulgated laws that allow parents to bind their children to arbitration agreements.[107] In some states, a statutory revocation period must

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STEDMAN'S MEDICAL DICTIONARY FOR THE HEALTH PROFESSIONS AND NURSING 538–539, 1535 (5th ed. 2005).

[103] Without being bound by an arbitration agreement, a child may bring a suit against a physician for injuries related to prenatal care or delivery until the child reaches the age of maturity because a minor's cause of action is tolled until that date. *See* Gregory T. Mueller, *Missouri's Malpractice Statute of Limitations*, 53 J. MO. B. 360, 362 (1997) (citing Strahler v. St. Luke's Hospital, 706 S.W.2d 7 (Mo. 1986)).

[104] Leading cases addressing the issue of a parent binding an unborn child are: Bolanos v. Khalatian, 283 Cal. Rptr. 209, 212 (Cal. Ct. App. 1991) (holding that an arbitration agreement signed by a mother bound all parties whose claims arose out of the treatments to the patient, including the unborn child); McKinstry v. Valley Obstetrics-Gynecology Clinic, 405 N.W.2d 88, 91 (Mich. 1987) (affirming that a parent could bind a minor child to arbitration); Wilson v. Kaiser Found. Hosps., 190 Cal. Rptr. 649, 655 (Cal. Ct. App. 1983) (holding that a child was bound to an arbitration agreement for a claim of prenatal injury when the mother signed the agreement).

[105] Crocca, *supra* note 101, at 88.

[106] In *United States v. Texas*, 507 U.S. 529 (1993), the Supreme Court announced the "speak directly" test. The Court held that statutes do not abrogate established common law principles unless the statute speaks directly to the question addressed by common law. *Id.* at 534. This principle is applied at the federal and state level and in various contexts of law. In Michigan, the now repealed Medical Malpractice Arbitration Act and section 2912g of the Michigan Compiled Laws modified the common law to permit a parent to bind a child to an arbitration agreement. MICH. COMP. LAWS ANN. §§ 600.5040 *et seq.* (West 1987 & Supp. 1993) (repealed 1993); MICH. COMP. LAWS § 600.2912g. The *McKinstry* case illustrates that the state statute allowing a parent to bind a child to arbitration spoke directly to the common law, thus allowing the statute to abrogate the common law rule that a parent has no authority to waive, release, or compromise claims by or against a child. *McKinstry*, 405 N.W.2d at 99.

[107] This issue of whether a parent can bind its child to arbitration is a controversial issue that has been generating a widespread debate in the arbitration field and state law. Douglas P. Gerber, Note, *The Validity of Binding Arbitration Agreements and Children's Personal Injury Claims in Florida After* Shea v. Global Travel Marketing, Inc., 28 NOVA L. REV. 167, 169–77 (2003) (discussing case law involving the binding of children's personal injury, negligence, and tort claims to arbitration).

This note focuses on the laws of California and Michigan. These two states have addressed the issues of arbitration in relation to a parent and a minor, and a mother and

expire before arbitration is mandated per agreement.[108] Other state statutes specifically provide that the parent has the authority to bind a minor child to arbitration for medical malpractice claims when the parent has signed on behalf of the child.[109] Furthermore, these agreements are not subject to

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her unborn child. On a broader scope, other states have upheld a parent's ability to waive a child's litigation rights in the absence of circumstance supported by public policy. Global Travel Mktg. v. Shea, 908 So. 2d 392, 396 (Fla. 2005). Hojnowki v. Vans Skate Park, 868 A.2d 1087, 1093–95 (N.J. Super. Ct. App. Div. 2005). Conversely, states have refused to enforce contract provisions addressing pre-injury tort or negligence claims based on public policy. *Global Travel Mktg.*, 908 So. 2d, at 400–02 (discussing case decisions in Washington, Utah, and Colorado that denied enforcement of agreements signed by parents on behalf of a minor child addressing liability issues). This Note does not argue the legality of whether a parent can bind a child to arbitration, but adopts the holdings of California and Michigan.

Unlike California, Michigan has reformed its arbitration statutes. In 1993, Michigan reformed its arbitration process and repealed the Medical Malpractice Arbitration Act, Mich. Comp. Laws 600. 5040 *et seq*. The reform included provisions requiring notice, damage caps of up to $75,000, rights of each party, and the ability to appeal. MICH. COMP. LAWS ANN. §600.2912 (West 2000). However, the power of a parent to enter into an arbitration agreement on behalf of the child is recognized by the Michigan Supreme Court. *McKinstry*, 405 N.W.2d at 99. Although, the Michigan legislature repealed its specific statutes on medical malpractice arbitration, Michigan law still allows a parent to bind a minor child to arbitration. MICH. COMP. LAWS ANN. § 600.2912g(3)(f) (West 2000); *see also* John P. Desmond, Comment, *Michigan's Medical Malpractice Reform Revisited—Tighter Damage Caps and Arbitration Provisions*, 11 T.M. COOLEY L. REV. 159, 180–81 (1994). Further, Michigan's Court of Appeals continues to interpret and enforce arbitration agreements under the requirements of the MMAA. *See* Kosmyna v. Botsford Comm. Hosp., 607 N.W.2d 134 (Mich. Ct. App. 2000).

[108] *See* MICH. COMP. LAWS ANN. § 600.5041 (West 1987 & Supp. 1993), repealed by 1993 Mich. Pub. Acts 78, provided in part: "The agreement shall provide that the person receiving health care treatment or his legal representative may revoke the agreement within 60 days after execution by notifying the health care provider in writing. A health care provider may not revoke the agreement after its execution."

[109] MICH. COMP. LAWS ANN. § 600.5046(2) (West 1987 & Supp. 1993), repealed by 1993 Mich. Pub. Acts 78, provided in part: "A minor child shall be bound by a written agreement to arbitrate disputes, controversies, or issues upon the execution of an agreement on his behalf by a parent or legal guardian. The minor child may not subsequently disaffirm the agreement." *See also* CAL. CIV. PROC. CODE § 1295(d) (West 1982): "Where the contract is one for medical services to a minor, it shall not be subject to disaffirmance if signed by the minor's parent or legal guardian." MICH. COMP. LAWS ANN. § 600.2912g(3)(f) (West 2000): "An arbitration agreement under this section signed on behalf of a minor or a person who is otherwise incompetent is enforceable and is not subject to disaffirmance or disavowal, if the minor or incompetent person was represented by an attorney at the time the written agreement was executed." *See also*

disaffirmance by the child, even when the child has reached the age of maturity.[110] The disaffirmance rule has been applied to unborn and not-yet-conceived children.[111] Therefore, in everyday practice, a mother can commit herself and any future children to a binding arbitration agreement. The combination of a state's interest in encouraging arbitration and the parents' willingness to participate in arbitration, provides reasonable justifications for treating arbitration agreements differently than other contracts executed by minors.[112] This can create a large impact on an insurance provider's predictions of litigation risks and insurance costs.

Alternatively, a parent's power to bind the child to arbitration can be considered implicit in the parent's right and duty to care for the child. It is within a parent's power to do what is necessary for the child. The ability of an authoritative figure, a parent, to bind a principle, a child, is analogous to the duties implied in agency law. An agency relationship contains an implied authority in which agents have the authority to do whatever is proper and usual to carry out the agency, such as binding employees that enrolled under a company's health care plan to arbitration for medical malpractice claims.[113] Statutory laws have permitted both types of authoritative parties, parents or agents, to bind their principles to arbitration agreements—laws that have been upheld by the courts.[114] The courts' strong stance in enforcing statutory laws that permit binding arbitration for medical malpractice claims within

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Crown v. Shafadeh, 403 N.W.2d 465, 466 (Mich. Ct. App. 1986); Crocca, *supra* note 101, at 24.

[110] Crocca, *supra* note 101, at 24.

[111] *Id.*

[112] Crocca, *supra* note 101, at 36; *see also* Osborne v. Arrington, 394 N.W.2d 67, 70 (Mich. Ct. App. 1986) (holding that "the Legislature has created a specific remedy for the disability for infants and minors which specifically prohibits minors from subsequently disaffirming or revoking an arbitration agreement by giving the parent that power"); *Crown*, 403 N.W.2d at 466. For the purposes of arbitration, the definition of "minor" can be construed to include an unborn child. *See* Bolanos v. Khalatian, 283 Cal. Rptr. 209, 212 (Cal. Ct. App. 1991); Wilson v. Kaiser Found. Hosps., 190 Cal. Rptr. 649, 655 (Cal. Ct. App. 1983); *McKinstry*, 405 N.W.2d at 91 (affirming that a parent could bind a minor child to arbitration).

[113] *See* Madden v. Kaiser Found. Hosps., 552 P.2d 1178, 1180 (Cal. 1976) (stating that CAL. CIV. CODE § 2319 grants an agent authority to carry out what is proper and usual "in carrying out" agency); *see also* Crocca, *supra* note 101, at 92.

[114] *See* Doyle v. Giuliucci, 401 P.2d 1, 3 (Cal. 1965) (rejecting that a minor, subject to a contract between the minor's father and the medical group that provided for arbitration of medical malpractice claims, could disaffirm an arbitration award); Turner v. Superior Court, 80 Cal. Rptr. 2d 84, 87–88 (Cal. Ct. App. 1998) (holding that a provision for arbitration in a contract was binding on the daughter of an employee's dependent).

various contexts of authoritative relationships demonstrates the legality of such a right.

Having arbitration replace the risk of potential litigation for the eighteen years following a delivery will help alleviate an OB/GYN's fear of lawsuits and will also play a key role in reducing medical malpractice insurance premiums. A series of cases have illustrated the courts' propensity to uphold medical arbitration agreements.[115] There are two approaches for including the unborn child in the arbitration agreement. The first approach is that if the mother is a member of an insurance or hospital group, the child becomes part of that group as soon as it is born, and therefore is bound by the agreement.[116] The second approach is that the term "patient" is inclusive of both the mother and the expected child when a pregnant mother is seeking care.[117] In these situations, the party's knowledge and voluntarily consent to arbitration for any and all claims arising from the alleged incident is critical.

The act of binding a child to arbitration could be interpreted as waiving the child's right to a jury trial resulting in a violation of the child's constitutional rights. However, state courts that have addressed this issue have held that binding arbitration imposed on the child does not violate the equal protection clauses[118] of either the federal or state constitutions because

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[115] Crocca, *supra* note 101, at 20–24.

[116] A well-recognized case on this issue is *Wilson v. Kaiser Found. Hosps.*, 190 Cal. Rptr. 649, 652 (Cal. Ct. App.1983). The court held that a newborn child became a member of the insurance group at birth and was thus governed by a binding arbitration agreement in the insurance contract. *Id.*

[117] *Bolanos*, 283 Cal. Rptr. at 212. In *Bolanos*, the agreement conformed to the statutory requirements of California's Code. The arbitration clause made it clear that *all* parties whose claims arose out of or related to the treatments of the patient were subject to the clause. Accordingly, the court applied the statutory prohibition against disaffirmance to the minor who was unborn at the time. *Id.*

[118] Crown v. Shafadeh, 403 N.W.2d 465, 466 (Mich. Ct. App. 1986). A child's rights are deemed to be adequately protected by a parent, thus requiring no special protection by the state. Infancy or age is not determined to be a suspect classification for equal protection purposes. *Id.* In addressing the constitutional issue, the U.S. Supreme Court has stated:

> The Equal Protection Clause [U.S. Const. amend. XIV] does, however, deny to States the power to legislate that different treatment be accorded to persons placed by a statute into different classes on the basis of criteria wholly unrelated to the objective of that statute. A classification must be reasonable, not arbitrary, and must rest upon some ground of difference having a fair and substantial relation to the object of the legislation, so that all persons similarly circumstanced shall be treated alike.

Reed v. Reed, 404 U.S. 71, 75–76 (1971) (internal quotations omitted).

the child's rights are being adequately protected by the parents.[119] Furthermore, in a civil action the right to a jury trial is a permissive right, not an absolute right.[120] The decision to arbitrate does not deprive a person (child) of a fundamental constitutional right.[121] The right to a jury trial is not a federal constitutional right, and under state constitutions it is a right that can be waived or is waived unless demanded.[122]

Two states that are leading authorities in binding arbitration agreements by parents are Michigan[123] and California.[124] California has a strong policy favoring arbitration, which is not exclusive to adults and encompasses

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[119] Crocca, *supra* note 101, at 35–36; *see also Crown*, 403 N.W.2d at 466 (reaffirming the trial court's holding to compel arbitration in a minor's medical malpractice suit because age was not a suspect class, and therefore did not violate the equal protection clause).

[120] McKinstry v. Valley Obstetrics-Gynecology Clinic, 405 N.W.2d 88, 95 (Mich. 1987).

[121] *Id.* "The Constitution of the United States does not confer a federal constitutional right to trial by jury in state court civil cases." *Id.* (citing Curtis v. Loether, 415 U.S. 189 (1974)).

[122] *Id.* The Michigan Constitution provides in pertinent part: "[t]he right of trial by jury shall remain, but shall be waived in all civil cases unless demanded by one of the parties in the manner prescribed by law." MICH. CONST. art. I, § 14. The California Constitution provides: "[i]n a civil cause a jury may be waived by the consent of the parties expressed as provided by statute." CAL. CONST. art I, § 16.

[123] The leading case under Michigan law is *McKinstry v. Valley Obstetrics-Gynecology Clinic*, 405 N.W.2d 88 (Mich. 1987). In *McKinstry*, the court held that a "parent of an unborn child, could bind the child, after birth, to arbitration disputes which arose out of prenatal care and delivery of child." The statute applied by the court is MICH. COMP. LAWS § 600.5040 *et seq.* (repealed 1993), which states in pertinent part: "[a] minor child shall be bound by a written agreement to arbitrate disputes, controversies, or issues upon the execution of an agreement on his behalf by a parent or legal guardian. The minor child may not subsequently disaffirm the agreement." *Id.* at 108.

[124] CAL. CIV. PROC. CODE §1295 (West 1982) states in pertinent part:

> Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration. . . . (c) Once signed, such a contract governs all subsequent open-book account transactions for medical services for which the contract was signed until or unless rescinded by written notice within 30 days of signature. Written notice of such rescission may be given by a guardian or conservator of the patient if the patient is incapacitated or a minor. (d) Where the contract is one for medical services to a minor, it shall not be subject to disaffirmance if signed by the minor's parent or legal guardian.

children's rights.[125] Under the relevant California statute, a parent *does* have the authority to bind a child, live or unborn, to an arbitration agreement.[126]

The possibility of binding an infant or fetus even before conception occurs is a legitimate option available to the mother. A fetus in utero is considered a child (minor) for purposes of a binding arbitration agreement.[127] For example, the purpose of Michigan's arbitration statute is to allow parents to bind their children, all of their children, to arbitration.[128] This purpose would be undermined if courts held that a distinction could be created based on when the child was born in regards to when parental consent was given.[129] This is consistent with the fact that neither a minor child nor a fetus in utero has the capacity to contract for medical care without a parent or guardian acting on behalf of the child.[130] Furthermore, under Michigan common law, a fetus in utero is a person for purposes of tort law if the fetus is born alive subsequent to the alleged injury or if the fetus was otherwise viable at the time of injury.[131] Therefore, a fetus in utero should also be considered a minor child for purposes of an arbitration statute and a parent's decision to bind the child to arbitration for any claims.

California state laws provide that there can be a binding effect on a child even if the child has yet-to-be conceived.[132] By extending the same principles that are applied to fetuses in utero, a parent is also able to bind a child that is not even in existence to arbitration. This proposition is based on that the premise that if non-signatories (minors, fetuses in utero) could be bound by agreements executed on their behalf, so should yet-to-be conceived

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[125] *See supra* notes 15, 117. California's strong policy on arbitration is embodied in CAL. CIV. PROC. CODE § 1295(d) (West 1982). This rule was added as part of the Medical Injury Compensation Reform Act. *Id.*

[126] *See* CAL. CIV. PROC. CODE § 1295(d) (West 1982); *see also* Bolanos v. Khalatian, 283 Cal. Rptr. 209, 212 (Cal. Ct. App. 1991); Wilson v. Kaiser Found. Hosps., 190 Cal. Rptr. 649, 654 (Cal. Ct. App. 1983).

[127] *McKinstry*, 405 N.W.2d at 98–99.

[128] *Id.* at 98; Crocca, *supra* note 101, at 90–91.

[129] Crocca, *supra* note 101, at 90–91.

[130] *Id.*

[131] *Id.* at 91.

[132] In *Pietrelli v. Peacock*, 16 Cal. Rptr. 2d 688, 689–91 (Cal. Ct. App. 1993), the court held that a mother who signed an arbitration agreement that included the phrase "persons, born or unborn, on behalf of whom I have the power to contract" was binding on any future children. *See also* Weldon E. Havins & James Dalessio, *Limiting the Scope of Arbitration Clauses in Medical Malpractice Disputes Arising in California*, 28 CAP. U. L. REV. 331, 344–47 (2000) (discussing the lineage of California cases dealing with binding an unborn child to an arbitration clause).

children.[133] A mother who elects to receive obstetric services under the arbitration agreement impliedly agrees to arbitration for her unborn child.[134] Furthermore, other areas of law recognize the ability of a person to act on behalf of, and affect the rights of, a person who has not yet come into existence.[135] Once a woman agrees to an arbitration agreement, her unborn child could also be subject to the agreement, and since a cause of action or injury could not occur prior to conception, once a child is conceived it is an unborn child and bound to arbitration.[136]

Conversely, a minor child may not be subject to arbitration if the arbitration agreement contained no reference to an unborn child when the parent signed. Thus, the services for the child would not be part of the health care agreement if the agreement did not purport to compel arbitration of *any* and *all* claims arising out of the treatment of the patient.[137] To ensure an arbitration agreement governs both the mother and the child, an arbitration agreement must make specific reference to the unborn child or provide that the agreement covers *any* and *all* claims arising out of treatment or care.

Obstetrics is a service that provides medical care for women and unborn children.[138] Therefore, the circumstance under which a female patient signs an arbitration agreement differs from an individual signing a contract that includes an arbitration clause. In the context of an OB/GYN and a potential child, the courts have held that the parent has indisputable legal authority to contract for medical services for the unborn child and therefore to bind the child to arbitration.[139]

IV. OB/GYN ARBITRATION MODEL

In an effort to reduce insurance premiums, the proposed arbitration model is based on a contractual relationship between the OB/GYN physicians and their insurance providers, which, through a discount matrix,

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[133] *See* Crocca, *supra* note 101, at 91–92.

[134] *Id.* at 88–91.

[135] *Id.* at 91 (stating that under estate laws, a child yet-to-be in existence (conceived) may be entitled to a testamentary bequest at a certain time).

[136] *Id.* at 88–91.

[137] *Id.*

[138] *See supra* text accompanying note 45.

[139] *See* discussion *supra* Part III.B.2.

will encourage OB/GYNs to enter into consensual arbitration agreements with their patients.[140]

A. *The Proposed Model for OB/GYNs and Insurance Providers*

On a basic level, the model will begin with the patient and the OB/GYN physician entering into an agreement that binds the physician and the patient, along with any unborn children, to arbitration. This agreement will establish that both parties have agreed to mandatory binding arbitration, and that any resolution resulting from arbitration will be binding on both parties.[141] Based on the percentage of patients within the OB/GYN's practice that have agreed to arbitration, the insurance provider will reduce the OB/GYN's medical malpractice insurance premiums. The reduction in premiums would be correlated to a pre-determined discount matrix based on the percentage of patients agreeing to arbitration within the OB/GYN's practice.

The model only identifies and proposes a solution between the insurance provider and the OB/GYN physician. It is merely a starting point in the fight to keep insurance premiums practicable. The arbitration insurance premium model is based on a formula that attempts to maintain the integrity of the insurance actuary algorithms[142] while establishing a discount mechanism to reduce OB/GYN medical malpractice premiums. The model is based on the following formula:

> ***Discounted Insurance Premium*** = Insurance Ratio (Percentage of Patient Base Agreeing to Arbitration) *multiplied by the* (Average Claims against an OB/GYN Physician) *multiplied by the* (Average Settlement Costs) *plus* ((1 *minus the* Percentage of Patient Base Agreeing to Arbitration) *multiplied by the* (Average Claims against an OB/GYN Physician) *multiplied by the*

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[140] The Arbitration Model could also possibly lend itself to incorporating incentives for the patients, such as reduced co-payments or a reduction in the monthly insurance costs, upon agreeing to an arbitration agreement. However, it is beyond the scope of this Note and must wait for another day.

[141] The specific elements of the arbitration agreement would be based on the state's statutory conditions for valid arbitration agreements. See *infra* note 183 (identifying that each state has its own arbitration laws).

[142] Insurance companies use actuaries, who are mathematicians, to calculate insurance risks and premiums using statistical analysis. U.S. Dept. of Labor, Bureau of Labor Statistics, Actuaries, www.bls.gov/oco/ocos041.htm (last visited Feb. 28, 2006); U.S. Dept. of Labor, Bureau of Labor Statistics, Insurance, www.bls.gov/oco/cg/cgs028.htm (last visited Feb. 28, 2006).

(Average Judgment Award)) ***divided*** by the estimated years the OB/GYN Physician will work.[143]

The first component of the formula is the "insurance ratio." The insurance ratio is calculated to maintain the existing margins established by the insurance providers.[144] It is a fixed factor that remains constant throughout the manipulation of the different variables. Using the national averages of each of the other variables in the formula, the insurance ratio is 0.32524.[145] By manipulating the "Percentage of Patient Base Agreeing to Arbitration" variable, a sliding scale is established that proposes an alterative annual insurance premium rate for a practicing OB/GYN.[146]

As an OB/GYN's patient base increases the percentage of patients agreeing to binding arbitration, the insurance company would adjust the OB/GYN's insurance rate to reflect the accurate discount.[147] For example, an OB/GYN in private practice that does not have *any* patients agreeing to mandatory binding arbitration would pay an annual insurance premium of $49,530.[148] If the same OB/GYN obtains a 20 percent patient base level

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[143] The formula represents a basic computation of a discount schedule based on the years remaining in service and the average claims within a career remaining fixed. However, if this model were put into practice, an equation accounting for the inverse relationship between the average claims against an OB/GYN in a career and the remaining years in service would need to be formulated and incorporated into the formula.

[144] Without having access to an insurance provider's actuary tables, I needed to create a fixed variable that would represent a pre-established profit margin of the insurance company.

[145] The ratio of 0.32524 is based on the following permutations: (($49,530 * 35 years)/2.6 claims per physician career * $2.05 million). The numbers used in the calculation are the following: $49,530 is the average insurance premium for OB/GYNs, *see supra* text accompanying note 17; 35 years is based on a 30 year old, beginning in private practice and retiring at the age of 65; 2.6 is the average number of claims filed against OB/GYNs during their careers, *see supra* note 35 and accompanying text; the figure of $2.05 million dollars is the median award for childbirth cases, *see supra* note 49 and accompanying text.

[146] *See* app. A.

[147] The adjustment would most likely occur on an annual basis.

[148] *See supra* note 17 and accompanying text. The savings based on the national average may not present a dramatic illustration, but in states where insurance premiums have reached a crisis stage, the savings can be significant. In a state, such as Ohio, where the OB/GYN insurance premiums are over $100,000, a 20% patient base agreeing to arbitration would reduce an annual medical malpractice insurance premium by almost $17,000 a year [$83,902=(.65666((.2)(2.6)($400,000)) + ((1-.2)(2.6)($2,050,000)))/35 years]. For Ohio's premium rate see *supra* note 14.

agreeing to arbitration, the annual insurance premium would be reduced by almost eight thousand dollars, which is just over a 16 percent discount.[149]

The proposed Discounted Insurance Premium would be available as an elected provision in the insurance providers' contracts. Therefore, the OB/GYN or OB/GYN group would be able to elect the provision based on their own conclusions of whether patients are likely to agree to arbitration. This incentive of reduced premiums, however, does not come without an investment from the OB/GYN. The arbitration agreement between the OB/GYN and the patient would not be an automated process.[150] The OB/GYN or group would have to invest time and administration in this initiative.[151]

B. *The Patient's Perception*

This model provides a strong incentive for OB/GYN physicians to work with their patients and set up contractual agreements for arbitration. One may contend that the model is not favorable to patients, argue whether parties have equal bargaining power, debate whether patients know they are waiving their right to a jury trial, or question whether third parties have the authority to bind others (children) to arbitration agreements. These arguments, however, are not dispositive of the proposed model.[152]

The argument that the parties do not have equal bargaining power is based on the belief that arbitration fees and costs are prohibitive.[153] Yet, having litigation as a primary method of procuring compensation can actually preclude one from receiving compensation. Only about two percent of victims of medical malpractice even file claims.[154] One of the major

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[149] The OB/GYN would pay an estimate of $41,557 [41,557= (.32524((.2)(2.6)($400,000)) + ((1-.2)(2.6)($2,050,000)))/35 years].

[150] *See* discussion *supra* Part III.B.1.

[151] The contract would have to be presented and explained to the patient prior to the patient's agreement and signature. The OB/GYN or the office administrator would need to complete this task. The arbitration clause should state in clear and conspicuous language that the agreeing party has read and understands the contract. This would preempt any contractual issue of unconscionability or ambiguity. *See* CAL. CIV. PROC. CODE § 1295(b).

[152] GAO-03-702, *supra* note 1, at 53; *see also* Stephen J. Ware, *Arbitration Clauses, Jury-Waiver Clauses, and Other Contractual Waivers of Constitutional Rights*, LAW & CONTEMP. PROBS., Winter/Spring 2004, at 167, 169–71.

[153] Lisa B. Bingham, *Control Over Dispute-System Design and Mandatory Commercial Arbitration*, LAW & CONTEMP. PROBS., Winter/Spring 2004, at 221, 235–36.

[154] Gibeaut, *supra* note 43, at 41.

factors supporting this statistic is that the potential damages are too small to justify the cost of litigating a case.[155] Furthermore, in medical malpractice suits, defendants prevail in 75 percent of the cases taken to trial.[156] Therefore, the combination of a low expected level of damages and plaintiffs succeeding in only 25 percent of the cases that actually reach a trial inevitably leads many plaintiffs to feel precluded from attempting to recover from injuries. With the use of arbitration, parties may increase their ability to retain lawyers and reach settlements because the cost of dispute resolution is reduced, thus diminishing the need for a pre-determined expectation of damages.

However, the use of arbitration would not necessarily equate to an increase in settlement payouts. Arbitration does not function as an incentive to settle claims because the risk of a jury award is extinguished. The arbitration process requires investigation and discovery to determine a physician's negligence or fault. Contrary to public perception, jury verdicts—not awards—are most likely consistent with neutral medical experts.[157] Based on the assumption that arbitration panels would produce like findings to a jury, plaintiffs would receive favorable results only 9 percent of the time.[158] Further, as discussed *supra*, 49.5 percent of the claims against OB/GYNs are dropped, dismissed, or settled without payment, and of the cases that do proceed to court OB/GYNS win 81.3 percent of the time.[159] This ratio would most likely remain intact since the only change is the elected forum and not the physician's standard of care.

Conversely, one may conclude that insurance companies would pay the same monetary amounts as jury awards if there was an increase in claims because of arbitration—assuming that 25 percent of these new claims would result in settlement payouts. However, this contention does not consider the economic advantages of arbitration from an execution aspect. The potential increase in settlement payouts may be offset by the reduced fees for

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[155] *Id.* Plaintiff attorneys take suits on a contingency basis so the expected prayer for damages must exceed the projected cost of litigation. Contingency fees average around forty percent of the jury award. *See generally* Stephen D. Annand & Roberta F. Green, *Legislative and Judicial Controls of Contingency Fees in Tort Cases*, 99 W. VA. L. REV. 81, 93 n.28 (1996) (discussing how contingency fees can mask the excessive fees being charged for tort litigation).

[156] Gibeaut, *supra* note 43, at 41.

[157] Neil Vidmar, *Medical Malpractice Lawsuits: An Essay on Patient Interests, The Contingency Fee System, Juries, and Social Policy*, 38 LOY. L.A. L. REV. 1217, 1237 (2005).

[158] *See supra* note 42.

[159] *See supra* text accompanying note 36.

arbitrating a claim versus litigating a claim, and also by the reduction of "nuisance settlements."[160] The cost of arbitration versus litigation provides a cost savings for defendants in both time and money.[161] Also, a decrease in nuisance settlements helps keep the economic scale tipped in arbitration's favor. A nuisance settlement is a payout that a defendant offers because it is less expensive then proceeding with a defense.[162] The previous practice of offering nuisance settlements claims is enough incentive for plaintiffs to pursue such claims.[163] However, the decreased costs and speedy resolution of arbitration deters a defendant from offering a generous nuisance settlement—thus increasing an insurer's cost-savings.[164] In light of these two examples, even if settlement payouts would increase due to an onslaught of arbitrated claims, insurance providers' cost savings could be sustained.

The debate on contractually waiving a person's right to a jury trial has been at the center of the controversy in arbitration law.[165] The proposed model is based on a patient signing a contract with the OB/GYN to arbitrate any dispute over a patient's current services or the future care of the patient and unborn children. Therefore, the arbitration clause would be governed under contract law, which provides that the standards for arbitration law consent are the same as for contract law consent.[166] Contractual consent is

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[160] A "nuisance settlement" represents the nuisance value of the suit "—the expense, harassment, and embarrassment that the defendant may endure in defending the suit." Ari Dobner, *Litigation for Sale*, 144 U. PA. L. REV. 1529, 1576 (1996).

[161] *See* AAA, ABA, AMA, COMMISSION ON HEALTH CARE DISPUTE RESOLUTION 30 (July 27, 1998). The use of arbitration for medical malpractice disputes reduces economic costs to both parties and is usually more expedient. Rallo, supra note 15, at 524. Arbitrated cases are typically cheaper than litigated cases because most of the arbitrated cases are resolved in less than a year. Gail Garfinkel Weiss, *Malpractice Mess: Is This the Way Out?*, MED. ECON., July 9, 2004, http://www.memag.com/memag/article/articleDetail.jsp?id=108984.

[162] Dobner, *supra* note 160, at 1576.

[163] A patient with a weak claim—dare to say a frivolous claim—may still bring such a claim merely to try and get the defending physician to pay a nuisance settlement. *Id.*; *see also* David J. Sokol, *The Current Status of Medical Malpractice Countersuits*, 10 AM. J.L. & MED. 439, 449 (1985) (stating that many medical malpractice claims are instituted to obtain a nuisance settlement). Nuisance settlements can also invoke a defending physician to file a countersuit in response to a frivolous suit or an abuse of process. *Id.* at 449. Physicians have received favorable outcomes at the trial and appellate levels, and have obtained out-of-court settlements. *Id.*

[164] *See* Michael Krauss, *Which Tort Reform Options? Some Solutions Work Much Better with the Nature of Tort Law*, LEGAL TIMES, Mar. 28, 2005, at 37–38.

[165] Ware, *supra* note 152, at 171.

[166] *Id.*

based on mutual assent—both parties' actions illustrate their intentions to enter into a contract. Nonetheless, exceptions such as unconscionability apply to both contract law and arbitration law.[167] Unconscionability is present in both contexts when there is a lack of understanding or a gross inequality in bargaining power.[168]

Critics of the FAA's contractual consent standard desire a higher standard requiring "knowing" consent.[169] A "knowing" standard resembles a contractual consent standard but further extends the unconscionability doctrine exception.[170] For an arbitration clause, also known as a jury waiver clause, to satisfy a knowing requirement, it cannot merely be present in the agreement but each party must be aware of the clause and understand it.[171]

The proposed OB/GYN arbitration model meets both levels of consent. The agreement to arbitrate between the patient and the OB/GYN is based on a contractual agreement, entered into voluntarily, which satisfies the current standard for contractual mutual assent, thus satisfying arbitration law consent. Furthermore, this arbitration agreement would satisfy a requirement

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> The FFA's contractual approach finds consent to arbitrate if the contract-law doctrine of mutual assent is satisfied. Importantly, contract law generally treats consent as an objective, rather than a subjective, phenomenon. In particular, formation of a contract requires, not mutual assent, but mutual *manifestations* of assent. The requirement to form a contract is not that parties *actually* assent to its terms. . . . [but] that they take actions—such as signing their names on a document or saying certain words—that would lead a reasonable person to believe that they have assented to the terms of the contract.

Id (internal quotations omitted).

[167] *Id.* at 172 (referring to the exceptions in contract law that would invalidate a contract despite a signature or "blanket" assent).

[168] RESTATEMENT (SECOND) OF CONTRACTS § 208 (1981).

[169] Ware, *supra* note 152, at 174.

[170] *Id.*

[171] Courts typically consider any actual negotiations over the clause, whether the clause was presented on a take-it-or-leave-it basis, the conspicuousness of the waiver, the degree of bargaining disparity between the parties, and the experience and sophistication of the party opposing the waiver. Courts have not been explicit as to how these factors relate to one another, but seem to consider them all together. Thus, it is not necessary to make a strong showing on all of the factors to uphold a jury waiver clause. Equally, it is not necessary to make a strong showing on all of the factors to defeat a jury waiver clause.

Id. (quoting Jean R. Sternlight, *Mandatory Binding Arbitration and the Demise of the Seventh Amendment Right to a Jury Trial*, 16 OHIO ST. J. ON DISP. RESOL. 669, 680–81 (2001)).

of knowing consent because the agreement is elected by the patient as an option presented by the OB/GYN, unlike an adhesion agreement that is a prerequisite to receiving services or goods.

The third and last concern from the patient's perspective is the authority to bind an unborn patient to arbitration.[172] The ability of a mother to bind an unborn child, even a child not yet conceived, may appear to limit that individual's right to elect litigation and a trial by jury. The courts have decided this controversial issue.[173] The standard hypothetical, reflective of a common circumstance, involves an individual patient contracting with an individual physician.[174] However, due to the unique nature of an OB/GYN's medical service, delivering a child, the standard hypothetical is not applicable because an OB/GYN is liable for an injury that is later discovered and allegedly related to the delivery of the child until the child reaches a designated age set by the state.[175] The typical period of liability for an OB/GYN is eighteen years for every child delivered.[176] Therefore, for arbitration to meet its objective as an influential method of reducing insurance premiums, all parties involved, not just the mother, need to be bound by the arbitration clause.

C. *Binding Judgments*

One of the strengths of the proposed Discounted Insurance Premium Model is the strong tendency of the courts to uphold arbitration clauses and decisions.[177] The designed purpose of arbitration is to render a final and binding decision with the same legal effect as a judicial determination.[178] Unlike the appellate review process for the judicial system, the law does not permit judicial review of the substantive aspects of the arbitral proceedings

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[172] *See* discussion *supra* Part III.B.2 (discussing the authority of mothers to bind unborn children to arbitration).

[173] *See* cases cited *supra* note 104.

[174] This particular circumstance is mirrored in *Bolanos v. Khalatian*, 283 Cal. Rptr. 209, 212 (Cal. Ct. App. 1991), in which the court upheld the arbitration agreement as binding on all parties, including born and unborn children. *See also* Havins & Dalessio, *supra* note 132, at 346–47.

[175] *See supra* note 103.

[176] *Id.*

[177] *See* cases cited *supra* note 104 (reviewing cases in the OB/GYN context, the listed cases adequately illustrate the courts' rationale in upholding arbitration clauses).

[178] Eric James Fuglsang, Comment, *The Arbitrability of Domestic Antitrust Disputes: Where Does the Law Stand?*, 46 DEPAUL L. REV. 779, 784 (1997) (describing the nature and purpose of arbitration and its interaction with the judicial system).

and generally does not permit vacating arbitral awards.[179] There are a few exceptions under which the court can order a vacation or modification of the award.[180] Thus, a patient is not completely barred from the judicial system when contractually agreeing to arbitrate but must fit into one of the limited exceptions.

In addition to challenging an arbitral award, the patient can also challenge the validity of the arbitration clause.[181] Under the proposed model, however, a patient may not find this to be a successful avenue for gaining judicial review of an arbitration clause. Arbitration agreements or clauses are generally held to be enforceable against the party that signed the agreement[182] as long as the agreement meets the statutory conditions of the

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[179] *Id.*

[180] The narrow exceptions for vacating an arbitral award are provided in 9 U.S.C. § 10, which states that United States courts:

> [W]herein the award was made may make an order vacating the award upon the application of any party to the arbitration— (1) [w]here the award was procured by corruption, fraud, or undue means. (2) [w]here there was evident partiality or corruption in the arbitrators, or either of them. (3) [w]here the arbitrators were guilty of misconduct in refusing to postpone the hearing, upon sufficient cause shown, or in refusing to hear evidence pertinent and material to the controversy; or of any other misbehavior by which the rights of any party have been prejudiced. (4) [or] [w]here arbitrators exceeded their powers, or so imperfectly executed them that a mutual, final, and definite award upon the subject matter submitted was not made.

9 U.S.C. § 10 (2000). An award can be modified or corrected under 9 U.S.C. § 11, which states:

> [A]n order modifying or correcting the award [may be made] upon the application of any party to the arbitration—(a) Where there was an evident material miscalculation of figures or an evident material mistake in the description of any person, thing, or property referred to in the award. (b) Where the arbitrators have awarded upon a matter not submitted to them, unless it is a matter not affecting the merits of the decision upon the matter submitted. (c) Where the award is imperfect in matter of form not affecting the merits of the controversy. The order may modify and correct the award, so as to effect the intent thereof and promote justice between the parties.

9 U.S.C. § 11 (2000).

[181] Andre V. Egle, *Back to* Prima Paint Corp. v. Flood & Conklin Manufacturing Co.*: To Challenge an Arbitration Agreement You Must Challenge the Arbitration Agreement*, 78 WASH. L. REV. 199, 200–202 (2003) (discussing the conflicting circuit court holdings on the issue of whether an arbitration agreement itself must be challenged or if it is sufficient that the contractual agreement is found to be void).

[182] Ann H. Nevers, *Medical Malpractice Arbitration in the New Millennium: Much Ado About Nothing*, 1 PEPP. DISP. RESOL. L.J. 45, 56–57 (2000) (discussing the lack of arbitration in medical malpractice claims even after courts have upheld arbitration clauses).

jurisdiction.[183] However, patients have had success when the clauses were found to be fraudulently induced or unconscionable.[184]

Accordingly, when parties consent to resolve any future disputes by arbitration, they waive their right to litigate the dispute in court.[185] The review process of an arbitration settlement is largely insulated by the FAA.[186] Once a decision is reached, the FAA imposes strict limits on a court's ability to overturn an arbitral award.[187] To that end, when parties agree to arbitrate, the law makes the clause enforceable and irrevocable.[188] Therefore, the insurance provider can incorporate as a factor, the calculated risk that the arbitration clause will be enforced, alleviating the potential risks of additional costs for litigation after the initial cost of arbitration.

V. CONCLUSION

As a result of increasing medical malpractice insurance premiums, women's health care is in a state of crisis with OB/GYN physicians eliminating services or leaving the specialty practice altogether. Yet, we, society and the legal community, fail to leverage the dispute resolution tools that are available today to implement an alternative approach to combat this issue. The specialty of OB/GYN poses unique challenges to establishing a dispute resolution model that will promote efficient and binding adjudication while having the predictability to create a cost benefit model to help lower insurance premiums. Arbitration seems to fit the bill.

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[183] Each state that has adopted an arbitration statute has identified requisite factors that must be met for an arbitration clause to be determined valid. *Id.* at 66 n.157. For example, in Michigan, to comply with statutory conditions, the arbitration clause must be in writing, accepted by the patient, not revoked within 60 days, state that it is not a prerequisite to health care or treatment, and in addition, the patient must be given a booklet containing specific provisions of the arbitration agreement. McKinstry v. Valley Obstetrics-Gynecology Clinic, 405 N.W.2d 88, 92 (Mich. 1987).

[184] Nevers, *supra* note 182, at 60.

[185] Andrew T. Guzman, *Arbitrator Liability: Reconciling Arbitration and Mandatory Rules*, 49 DUKE L.J. 1279, 1301 (2000) (discussing the process an individual follows, under existing law, when she consents to have future disputes settled through arbitration).

[186] Elizabeth G. Thornburg, *Contracting with Tortfeasors: Mandatory Arbitration Clauses and Personal Injury Claims*, LAW & CONTEMP. PROBS., Winter/Spring 2004, at 253, 266 (discussing the interjection of mandatory arbitration clauses into contractual agreements).

[187] *Id.*; *see also* Guzman, *supra* note 185, at 1301.

[188] Guzman, *supra* note 185, at 1301.

An OB/GYN shares the joy of bringing new life into the world, but is also required to carry the risk of liability for eighteen years. Arbitration can provide a method to minimize the risk thus, resulting in lower insurance premiums. An OB/GYN and a patient can enter into a contractual relationship that will ensure that the parties will arbitrate all future disputes—decreasing the exposure of extraordinary jury awards. The well established jurisprudence that arbitration clauses and arbitral awards will unlikely be overturned provides strength and stability to the model. Therefore, by implementing a binding arbitration model, we are taking the first step towards ensuring that women will receive the best care available.

Appendix A

Insurance Premium Discount Matrix*	
0%	$49,530
10%	$45,543
20%	$41,557
30%	$37,570
40%	$33,584
50%	$29,597
60%	$25,611
70%	$21,624
80%	$17,638
90%	$13,651

* This discount matrix is based on the national average.

Annual Premium	Estimated Years of Service	Average Claims Against Physician	Average Jury Award	Average Settlement	Percentage of Patient Base Agreeing to Arbitration
$49,530	35	2.6	$2,050,000	$400,000	0
$49,530	35	2.6	$2,050,000	$400,000	10%
$49,530	35	2.6	$2,050,000	$400,000	20%
$49,530	35	2.6	$2,050,000	$400,000	30%
$49,530	35	2.6	$2,050,000	$400,000	40%
$49,530	35	2.6	$2,050,000	$400,000	50%
$49,530	35	2.6	$2,050,000	$400,000	60%
$49,530	35	2.6	$2,050,000	$400,000	70%
$49,530	35	2.6	$2,050,000	$400,000	80%
$49,530	35	2.6	$2,050,000	$400,000	90%
Insurance Ratio** = 0.32524					

** Insurance Ratio is the fixed variable calculated to maintain the insurance provider's margin.

State Example of a discount matrix for a state that averages an annual payment of $100,000 for medical malpractice insurance.

State X Insurance Premium Discount Matrix	
0%	$100,000
10%	$91,951
20%	$83,902
30%	$75,854
40%	$67,805
50%	$59,756
60%	$51,707
70%	$43,659
80%	$35,610
90%	$27,561